PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY - Insured

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$1,250 Individual $2,500 Family	$2,500 Individual $5,000 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance Applies to all expenses unless otherwise stated.	15%	40%
Payment Limit (per calendar year)	$6,050 Individual $12,100 Family	$6,050 Individual $12,100 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of pocket expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Not applicable	Not applicable
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 every 12 month for Adults Ages 21+	Covered 100%; deductible waived	40%; after dedictuble
Routine Well Child Exams/ Immunizations Unlimited exams for children to age 12; 3 exams per year for children age 12 up to age 21	Covered 100%; deductible waived	40%; after dedictuble
Routine Gynecological Care Exams One exam per calendar year. Includes routine	Covered 100%; deductible waived	40%; after dedictuble
Pap Smear and related lab fees	Covered 100%; deductible waived	40%; after dedictuble
Routine Mammograms	Covered 100%; deductible waived	40%; after dedictuble
Women's Health Includes: Screening for gestational diabetes, HPV (Human Papillomavirus) DNA testing, counseling for sexually transmitted Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered;
Routine Digital Rectal Exam / Prostate-	Covered 100%; deductible waived	Member cost sharing is based on the
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Eye Exams (1 every 12 Months)	Covered 100%; deductible waived	40%; after dedictuble
Routine Hearing Screening (1 every 24 Mos)	Covered 100%; deductible waived	Not Covered

PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to Non-Specialist (non-surgical)	15% after deductible	40%; after dedictuble
E-visit to non-Specialist	15% after deductible	40%; after dedictuble
An e-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare		
E-visit to Specialist	15% after deductible	40%; after dedictuble
An e-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare		
Walk-in Clinics	15% after deductible	40%; after dedictuble
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for		
Allergy Testing	Member cost sharing is based on the type of service performed and the	Member cost sharing is based on the type of service performed and the
Allergy Injections	Member cost sharing is based on the	Member cost sharing is based on the
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray	15% after deductible	40%; after dedictuble
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable		
physician's office visit member cost sharing		
Diagnostic X-ray for Complex Imaging	15% after deductible	40%; after dedictuble
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	15% after deductible	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	15% after deductible	15% after deductible
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	15% after deductible	40%; after dedictuble
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	15% after deductible	40%; after dedictuble
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	Covered same as Inpatient Hospital services.	Covered same as Inpatient Hospital services.
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	15% after deductible	40%; after dedictuble
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	Covered same as Inpatient Hospital	Covered same as Inpatient Hospital

Outpatient	15% after deductible	40%; after dedictuble
Includes treatment facility services		
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
Treatment Facility -- Inpatient	15% after deductible	40%; after dedictuble
Treatment Facility -- Outpatient	15% after deductible	40%; after dedictuble
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	15%	50%
Home Health Care	15	50%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing - Outpatient (Limited to	15% after deductible	50%
Outpatient Short-Term Rehabilitation	15% after deductible	40%
Limited to 60 visits per calendar year.		
Includes speech, physical, and occupational therapy.		
Includes habilitative services for covered individuals to age 21 for services diagnosed with congenital and genetic birth		
Outpatient Speech Therapy		
Outpatient Physical and Occupational Therapy	15%	40%
Habilitative Services	Member cost sharing is based on the	Member cost sharing is based on the
Unlimited treatment for children under age 21 with congenital or genetic birth defects to enhance the child's ability to function		
Spinal Manipulation Therapy	15% after deductible	**40%**
Durable Medical Equipment	5%	50%
Maximum annual benefit of $10,000 per member per calendar year		
Transplants	5% Preferred coverage is provided at	50% Non-Preferred coverage is
Bariatric	Covered same as Preferred Inpatient	Covered same as Non Preferred
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Comprehensive Infertility Services		
Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction		
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Retail	$5 copay for generic drugs, $10 copay for formulary brand-name drugs, and $25 copay for non-formulary brand-	50% of submitted cost after $5 copay for generic drugs, $10 copay for formulary brand-name drugs, and $25
Mandatory Generic with DAW override (MG W/DAW Override) - the member pays the applicable copay. If the physician requires brand, member would pay brand name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.		
	copay for formulary brand-name drugs, and $120 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna RX	
Mail Order	Hamoe Delivery	Not Applicapble
GENERAL PROVISIONS		
	After effective date: Full Postponement	

For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-888-982-3862. If your plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. . Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
If you require language assistance from an Aetna representative, please call Member Services' multilingual hotline at **1-888-982-3862** (140 languages are available. You must ask for an interpreter). **TDD 1-800-628-3323** (hearing impaired only).
Si necesita asistencia lingüística de un representante de Aetna, contamos con una línea directa de Servicios a Miembros disponible en varios idiomas. Comuníquese al **1-888-982-3862** (140 idiomas disponibles. Debe solicitar un intérprete). **TDD 1-800-628-3323** (para personas con problemas de audición únicamente).

For more information about Aetna plans, refer to **www.aetna.com**.